PATIENT REQUIRED PAPERWORK FOR DIABETIC SHOE CLINIC:

1. **BRING ALL YOUR INSURANCE CARDS, INCLUDING MEDICARE AND MEDICAID.**
2. **Attached doctor's order must be completed as such by your primary care MD or DO:**

A. Patient's name, DOB, Address.

B. MD's printed name and NPI #.

C. Section A and B one item must be checked or circled. Section A is your Diabetic diagnosis. Section B is the secondary diagnosis which is your foot condition(if unknown, the diagnosis can be taken from podiatry notes.)

D. Signed by your MD and dated.

3. **CHART NOTES from an exam/visit with the same MD or DO that completed your doctor's order in #2 above.** (Dated no earlier than 5 months before you are being measured.)

This visit must show the following details:

A. The type of Diabetes patient has (such as E11.9)

B. Method of monitoring (A1c test result and date or BS test result and date. If no recent results are available it should at least mention when they will be taken or that A1C labs have been ordered.)

C. How it is controlled- either diet controlled or Diabetic medication, dosage and frequency.

D. Podiatry notes or Foot condition added to this visit-If using poor circulation it must say *pedal pulses are weak, oe diminished, or they have numbness and tingling in the feet (it can NOT just say poor circulation.) It can also say reduced sensation of the feet. Or it can say, Onychauxia or* Onychomycosis, *Tineas Pedias, previous foot ulceration, right or left bunion, right or left hammer toes, right or left drop foot, right or left heel spurs, right or left foot callus, right or left amputation and which digit. (podiatry notes within 5 months of when you are being measured.)*

4. If the visit on your Diabetes in #3 was done by a NP or PA, the MD from the practice must cosign with a statement that "they agree to the findings and plan of the NP or PA" (This MUST BE THE SAME MD THAT SIGNS THE DOCTOR'S ORDER EXPLINED IN #2 ABOVE)

**** This exam must be in their regular chart note format, not in a letter or fill in the blank format.

Pro Medical East LLC
A GARDEN STATE MEDICAL SUPPLY COMPANY

PHYSICIAN ORDER AND CERTIFYING PHYSICIAN STATEMENT FOR DIABETIC SHOES AND INSERTS

PATIENT INFORMATION

NAME _____ ADDRESS _____ CITY _____ STATE ___ ZIP _____

INSURANCE _____ NUMBER _____ PHONE _____ SEX ___ DOB _____

PHYSICIAN INFORMATION

PHYSICIAN _____ NPI# _____ FAX _____

ADDRESS _____ CITY, STATE, ZIP _____ PHONE _____

APPROVED SERVICES

All information must be filled out completely and reviewed by physician

Required. 1 pair unless otherwise noted

☐ **A5500** Extra Depth Diabetic Shoes

Required. Choose One. 3 Pair unless otherwise noted.

☐ **Custom** Molded Inserts ☐ **Heat** Molded Inserts

Optional

☐ **L5000** PARTIAL FOOT, SHOE INSERT WITH LONGITUDINAL ARCH, TOE FILLER ☐ LEFT ☐ RIGHT

SECTIONS A & B MUST BE COMPLETED FOR PRESCRIPTION TO BE VALID

SECTION A - PRIMARY DIAGNOSIS

Required. Choose One. DIABETES MELLITUS (Please fill in correct ICD-10 code)

TYPE I
W/ DIABETIC NEUROPATHY ☐ E10.40
W/O COMPLICATIONS ☐ E10.9

TYPE II
W/ DIABETIC NEUROPATHY ☐ E11.40
W/O COMPLICATIONS ☐ E11.9

OTHER _____

SECTION B - SECONDARY DIAGNOSIS

Requred. Choose at least 1.

I further determined that the patient has one or more of the following conditions: (Check all that apply and fill in ICD-10 code)

HISTORY OF PREVIOUS FOOT ULCERATION
☐ Z86.31

HISTORY OF PRE-ULCERATIVE CALLUS
☐ L84

POOR CIRCULATION
☐ I87.2

OTHER _____

HISTORY OF PARTIAL OR COMPLETE AMPUTATION OF THE FOOT

FOOT
LT ☐ Z89.432 RT ☐ Z89.431

ANKLE
LT ☐ Z89.442 RT ☐ Z89.441

GREAT TOE
LT ☐ Z89.412 RT ☐ Z89.411

OTHER TOE(S)
LT ☐ Z89.422 RT ☐ Z89.421

FOOT DEFORMITY

HAMMERTOES
LT ☐ M20.42 RT ☐ M20.41

BUNIONS
LT ☐ M20.12 RT ☐ M20.11

HEEL SPURS
LT ☐ M77.32 RT ☐ M77.31

OTHER _____

PHYSICIAN SIGNATURE AND PHYSICIAN INFORMATION MUST MATCH FOR PRESCRIPTION TO BE VALID
SIGNATURE STAMPS ARE NOT ACCEPTABLE

I certify that I or an NP/PA on my staff am treating this patient under a comprehensive plan of care for their diabetes. I certify that the information provided is true and correct and that I have thoroughly documented and/or approved the patient's medical necessity for the product(s) ordered. I will provide all required supporting documentation to Pro Medical East upon request.

MD OR DO, PECOS ENROLLED ONLY
PHYSICIAN SIGNATURE _____ DATE _____

PLEASE FAX PRESCRIPTION TO 603-835-3229

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